BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
JOSEPH EMANUEL PIERSON, M.D.	)	**Case No. 800-2014-003853**
Physician's and Surgeon's Certificate No. G 53815	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 9, 2018.

IT IS SO ORDERED: January 12, 2018.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson, J.D., Chair
Panel B

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **JOSEPH EMANUEL PIERSON, M.D.** **6333 Wilshire Boulevard, Suite 411** **Los Angeles, CA 90048** **Physician's and Surgeon's Certificate No. G53815** Respondent.	Case No. 800-2014-003853 OAH No. 2017060257 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Martin W. Hagan, Deputy Attorney General.

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2. Respondent Joseph Emanuel Pierson, M.D. (Respondent) is represented in this proceeding by Joel Bruce Douglas, Esq., of Bonne Bridges Mueller O'Keefe & Nichols, whose address is: 355 South Grand Ave., Ste. 1750, Los Angeles, CA 90071-1562.

3. On or about October 15, 1984, the Board issued Physician's and Surgeon's Certificate No. G53815 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2014-003853, and will expire on December 31, 2017, unless renewed.

JURISDICTION

4. On March 16, 2017, Accusation No. 800-2014-003853 was filed against Respondent before the Board. A copy of Accusation No. 800-2014-003853 and all other statutorily required documents were properly served on Respondent on March 16, 2017. Respondent timely filed his Notice of Defense contesting the Accusation.

5. On October 16, 2017, First Amended Accusation No. 800-2014-003853 was filed against Respondent before the Board and is currently pending against Respondent. A copy of First Amended Accusation No. 800-2014-003853, along with a Supplemental Statement to Respondent, were properly served on Respondent on October 16, 2017. A true and correct copy of First Amended Accusation No. 800-2014-003853 is attached as Exhibit A and incorporated herein by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2014-003853. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision;

and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent agrees that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations in First Amended Accusation No. 800-2014-003853, and that he has thereby subjected his Physician's and Surgeon's Certificate No. G53185 to disciplinary action. Respondent further agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

10. Respondent further agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition for revocation of probation is filed against him before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2014-003853 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not

be disqualified from further action by having considered this matter.

13. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Board does not, in its discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Settlement and Disciplinary Order be rejected for any reason by the Board, respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

14. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

15. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree the Board may, without further notice to or opportunity to be heard by respondent, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G53185 issued to Respondent Joseph Emanuel Pierson, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years from the effective date of the Decision on the following terms and conditions:

1. **PRESCRIBING PRACTICES COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

2. **MEDICAL RECORD KEEPING COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The

medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. **MONITORING - PRACTICE**. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and First Amended Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, First Amended Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and First Amended Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

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Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

4. **NOTIFICATION**. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First Amended Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. **SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES**. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

6. **OBEY ALL LAWS**. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. **QUARTERLY DECLARATIONS**. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. **GENERAL PROBATION REQUIREMENTS**

Compliance with Probation Unit. Respondent shall comply with the Board's probation unit.

Address Changes. Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

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Place of Practice. Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California. Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. **INTERVIEW WITH THE BOARD OR ITS DESIGNEE**. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. **NON-PRACTICE WHILE ON PROBATION**. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine. Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

11. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

12. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If a First Amended Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate

and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. **PROBATION MONITORING COSTS**. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Joel Bruce Douglas, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/08/2017

JOSEPH EMANUEL PIERSON, M.D.
Respondent

I have read and fully discussed with Respondent Joseph Emanuel Pierson, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 11/14/17

JOEL BRUCE DOUGLAS, ESQ.
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 11/14/2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2014-003853

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **JOSEPH E. PIERSON, M.D.** **6333 Wilshire Boulevard, Suite 411** **Los Angeles, CA 90048** **Physician's and Surgeon's** **No. G53815,** Respondent.	Case No. 800-2014-003853 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 15, 1984, the Medical Board issued Physician's and Surgeon's Number G53815 to Joseph E. Pierson, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on December 31, 2017, unless renewed.

JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on March 16, 2017, in the above-entitled action, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, be placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded and ordered to complete relevant educational courses, or have such other action taken in relation to discipline as the Board or an administrative law judge deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure

constitutes a separate and distinct breach of the standard of care.

". . . ."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 3501[1] of the Code states:

"...

"(a)(4) 'Physician assistant' means a person who meets the requirements of this chapter and is licensed by the board.

"(a)(5) 'Supervising physician' means a physician and surgeon licensed by the Medical Board of California or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation for improper use of a physician assistant.

"(a)(6) 'Supervision' means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant.

"(a)(7) 'Regulations' means the rules and regulations as set forth in Chapter 13.8 (commencing with Section 1399.500) of Title 16 of the California Code of Regulations.

"...

[1] California Senate Bill 1236, chapter 332, resulted in minor revisions to Business and Professions Code sections 3501 and 3502 which became effective January 1, 2013. These revisions primarily dealt with changing the designation of the Physician Assistant Committee to the Physician Assistant Board and making various conforming changes relative to the change in designation. (See Stats. 2012, c.332 (S.B. 1236, § 27).) Additional revisions were made to Code sections 3501, 3502, and 3502.1 effective January 1, 2016, which are not set forth herein based on the dates of the underlying conduct alleged in this Accusation. (See Stats. 2015., c.536, S.B. 337, § 2, eff. January 1, 2016.)

"(a)(10) 'Delegation of services agreement' means the writing that delegates to a physician assistant from a supervising physician the medical services the physician assistant is authorized to perform consistent with subdivision (a) of Section 1399.540 of Title 16 of the California Code of Regulations.

"(a)(11) 'Other specified medical services' means tests or examinations performed or ordered by a physician assistant practicing in compliance with this chapter or regulations of the Medical Board of California promulgated under this chapter.

"(b) A physician assistant acts as an agent of the supervising physician when performing any activity authorized by this chapter or regulations adopted under this chapter."

8. Section 3502 of the Code states:

"(a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the board prohibiting that supervision or prohibiting the employment of a physician assistant.

"(b) Notwithstanding any other provision of law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon. [¶] The supervising physician and surgeon shall be physically available to the physician assistant for consultation when such assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

"(c)(1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

"(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

"(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care.

"(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

"(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

"(2) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant. The physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

"(3) Notwithstanding any other provision of law, the Medical Board of California or board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

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"(d) No medical services may be performed under this chapter in any of the following areas:

"(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

"(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

"(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

"(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

"(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501."

9. Section 3502.1 of the Code states:

"(a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

"(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

"(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of

illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

"(b) "Drug order," for purposes of this section, means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

"(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

"(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

"(2) A physician assistant shall not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

"(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

"(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and telephone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician

assistant and shall otherwise comply with Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

"(e) The supervising physician and surgeon shall use either of the following mechanisms to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances:

"(1) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed, countersigned, and dated by a supervising physician and surgeon within seven days.

"(2) If the physician assistant has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course (A) meets the standards, including pharmacological content, established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of Regulations, and (B) is provided either by an accredited continuing education provider or by an approved physician assistant training program, the supervising physician and surgeon shall review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out. Completion of the requirements set forth in this paragraph shall be

verified and documented in the manner established in Section 1399.612 of Title 16 of the California Code of Regulations. Physician assistants who have a certificate of completion of the course described in paragraph (2) of subdivision (c) shall be deemed to have met the education course requirement of this subdivision.

"(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

". . ."

10. California Code of Regulations, title 16, section 1399.540, states:

"(a) A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.

"(b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

". . .

"(d) A physician assistant shall consult with a physician regarding any task, procedure or diagnostic problem which the physician assistant determines exceeds his or her level of competence or shall refer such cases to a physician."

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11. California Code of Regulations, title 16, section 1399.541, states:

"Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician. [¶] In any setting, including for example, any licensed health facility, out-patient settings, patients' residences, residential facilities, and hospices, as applicable, a physician assistant may, pursuant to a delegation and protocols where present:

"(a) Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services described in Section 1399.541(b) through Section 1399.541(i) inclusive; and record and present pertinent data in a manner meaningful to the physician.

"(b) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services.

"(c) Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.

"(d) Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.

"(e) Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.

"(f) Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring

continuing care, including patients at home.

"(g) Initiate and facilitate the referral of patients to the appropriate health facilities, agencies, and resources of the community.

"(h) Administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with the provisions of subdivisions (a)-(f), inclusive, of Section 3502.1 of the Code.

"(i)(1) Perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation which indicates that the physician assistant is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of [a] supervising physician.

"(2) A physician assistant may also act as first or second assistant in surgery under the supervision of [a] supervising physician."

12. California Code of Regulations, title 16, section 1399.542, states:

"The delegation of procedures to a physician assistant under Section 1399.541, subsections (b) and (c) shall not relieve the supervising physician of primary continued responsibility for the welfare of the patient."

13. California Code of Regulations, title 16, section 1399.545, states:

"(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

"(b) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

"(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.

"(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.

"(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

"(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;

"(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;

"(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the

patient;

"(4) Other mechanisms approved in advance by the board.

"(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision."

14. California Code of Regulations, title 16, section 1399.545, states:

"(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

"(b) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

"(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.

"(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.

"(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

"(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;

"(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;

"(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing

diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;

"(4) Other mechanisms approved in advance by the board.

"(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision."

15. California Code of Regulations, title 16, section 1399.546, states:

"(a) Each time a physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also record in the medical record for that episode of care the supervising physician who is responsible for the patient. When a physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

"(b) If the electronic medical record software used by the physician assistant is designed to, and actually does, enter the name of the supervising physician for each episode of care into the patient's medical record, such

automatic entry shall be sufficient for compliance with this recordkeeping requirement.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patient M.C., as more particularly alleged hereinafter:

PATIENT M.C.

17. On or about July 16, 2012, patient M.C., a then-28-year-old female was seen in respondent's clinic as a referral from another physician. According to the Physical Exam Note for this visit, patient M.C. had a car accident three months before. The patient's blood pressure was listed as 110/75 and the patient was listed as having a normal physical examination for the head and neck, lungs, heart, abdomen, neurological and extremities. The lumbosacral spine was noted as having a decreased range of motion and positive on the straight leg raising test. The plan was listed as treating with Robaxin, Motrin, with a notation to add Clonidine 0.1 mg twice daily (with no explanation as to why the Clonidine was added.) As part of this visit, respondent filled out an Aetna Attending Physician's Statement and Employment Development Department ("EDD") form for patient M.C. The assessment, as set forth in the Attending Physician's Statement and EDD forms, was lumbosacral – low back pain. The treatment plan included medication and "back rest." The medications on the Attending Physician Statement form were listed as Naprosyn, Flexeril, Zoloft, and Norco 10/325 mg with a notation that "Vicoden ES causes rash." The Attending Physician Statement indicated that the next office visit was scheduled for September 17, 2012. On this date, patient M.C. was issued a prescription for hydrocodone APAP (acetaminophen)[2] 7.5/750 mg (#60). The note associated with this visit is

[2] Hydrocodone APAP (Lorcet®, Lortab®, Norco® and Vicodin®), generally used for the treatment of moderate to severe pain, is a hydrocodone combination of hydrocodone bitartrate and acetaminophen that formerly was a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. The Drug Enforcement Administration reclassified hydrocodone combination products from Schedule III to Schedule II effective October 6, 2014.

cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

18. According to the CURES report for patient M.C., during the period of on or about July 17, 2012, through on or about September 16, 2012, patient M.C. filled the following prescriptions for the controlled substances listed below:

Date Filled	Drug Name	Strength	Quantity	Prescriber
07-30-2012	Hydrocodone/APAP	7.5/750 mg	60	Respondent
08-06-2012	Hydrocodone/APAP	10/325 mg	60	Respondent's P.A. – G.T.
08-14-2012	Hydrocodone/APAP	10/325 mg	60	Respondent's P.A. – G.T.
08-23-2012	Hydrocodone/APAP	10/325 mg	60	Another Physician
08-29-2012	Hydrocodone/APAP	10/325 mg	20	Another Physician
08-31-2012	Hydrocodone/APAP	10/325 mg	60	Another Physician
09-07-2012	Hydrocodone/APAP	10/325 mg	60	Another Physician
09-14-2012	Hydrocodone/APAP	10/325 mg	60	Another Physician

19. On or about September 17, 2012, Physician Assistant G.T. had an office visit with patient M.C. According to the note for this visit, the patient reported significant low back pain and reported she had a history of a disc fracture in 2011 allegedly arising from a motor vehicle accident with pain list as 8 out of 10 which increased with activity. The assessment was disc disease, hypertension (HTN) (blood pressure 111/80) and anxiety. The plan was to treat with Baclofen, Clonodine, Norco, Zoloft 50 mg daily, and extended disability until November 17, 2012. The progress note for the visit did not identify the name of the supervising physician for Physician Assistant G.T. and there is no co-signature by respondent as the supervising physician of Physician Assistant G.T. Another EDD form was filled out which indicated patient M.C. was incapable of working with an anticipated return to work date of November 17, 2012. The diagnoses on the EDD form were listed as Degenerative Disc Disease and Anxiety. One portion of the EDD form indicated "needs Pain Management/Ortho Referral." There was no indication

that patient M.C. did ever, in fact, have a consultation with a pain management specialist or an orthopedic specialist. The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

20. According to the CURES report for patient M.C., during the period of on or about September 18, 2012, through on or about July 20, 2014, patient M.C. filled the following prescriptions for the controlled substances listed below:

Date Filled	Drug Name	Strength	Quantity	Prescriber
09-18-2012	Hydrocodone/APAP	10/325 mg	70	Physician Assistant G.T.
09-22-2012	Hydrocodone/APAP	10/325 mg	60	Another Physician
09-27-2012	Hydrocodone/APAP	10/325 mg	60	Another Physician
10-03-2012	Hydrocodone/APAP	10/325 mg	70	Physician Assistant G.T.
10-08-2012	Hydrocodone/APAP	10/325 mg	30	Another Physician
10-12-2012	Hydrocodone/APAP	10/325 mg	20	Another Nurse Practitioner
10-22-2012	Hydrocodone/APAP	10/325 mg	60	Another Physician
10-30-2012	Hydrocodone/APAP	10/325 mg	30	Another Practitioner
11-01-2012	Hydrocodone/APAP	10/325 mg	70	Physician Assistant G.T.
11-01-2012	Carisoprodol	350 mg	60	Physician Assistant G.T.
11-16-2012	Hydrocodone/APAP	10/325 mg	70	Physician Assistant G.T.
11-23-2012	Hydrocodone/APAP	5/325 mg	20	Another Physician
11-27-2012	Hydrocodone/APAP	10/325 mg	70	Respondent
11-27-2012	Carisoprodol[3]	350 mg	60	Respondent
11-27-2012	Diazepam	5 mg	30	Respondent

[3] Carisoprodol (Soma®) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of acute and painful musculoskeletal conditions. According to the Drug Enforcement Administration (DEA) Office of Diversion Control, Carisoprodol (Soma®) "abuse has escalated in the last decade in the United States" and "continues to be one of the most commonly diverted drugs." The DEA warns that "[w]ith prolonged abuse at high dosage, carisoprodol can lead to tolerance, dependence and withdrawal symptoms in humans." (See generally, Drug Enforcement Administration, Office of Diversion Control, Drug & Chemical Evaluation Section, www.deadiversion.usdoj.gov/drug_chem_info/carisoprodol/carisoprodol.pdf)

Date Filled	Drug Name	Strength	Quantity	Prescriber
11-29-2012	Carisoprodol	350 mg	60	Physician Assistant G.T.
12-07-2012	Hydrocodone/APAP	10/325 mg	70	Respondent
12-17-2012	Hydrocodone/APAP	10/325 mg	70	Respondent's P.A. - G.T.
12-17-2012	Hydrocodone/APAP	10/325 mg	6	Another Nurse Practitioner
12-27-2012	Carisoprodol	350 mg	60	Respondent's P.A. - G.T.
12-30-2012	Carisoprodol	350 mg	60	Respondent
12-31-2012	Hydrocodone/APAP	10/325 mg	70	Respondent's P.A. - G.T.
01-07-2013	Phentermine HCL	37.5 mg	30	Respondent's P.A. - G.T.
01-07-2013	Hydrocodone/APAP	10/325 mg	70	Respondent's P.A. - G.T.
01-22-2013	Hydrocodone/APAP	10/325 mg	70	Respondent's P.A. - G.T.
01-26-2013	Carisoprodol	350 mg	60	Respondent's P.A. - G.T.
02-04-2013	Hydrocodone/APAP	10/325 mg	45	Respondent's P.A. - G.T.
02-04-2013	Carisoprodol	350 mg	60	Respondent's P.A. - G.T.
02-05-2013	Hydrocodone/APAP	10/325 mg	25	Respondent's P.A. - G.T.
02-19-2013	Hydrocodone/APAP	10/325 mg	70	Respondent's P.A. - G.T.
02-27-2013	Carisoprodol	350 mg	60	Respondent's P.A. - G.T.
03-18-2013	Hydrocodone/APAP	10/325 mg	25	Respondent's P.A. - G.T.
03-18-2013	Hydrocodone/APAP	10/325 mg	45	Respondent's P.A. - G.T.
03-26-2013	Carisoprodol	350 mg	60	Respondent's P.A. - G.T.
04-01-2013	Hydrocodone/APAP	10/325 mg	45	Respondent's P.A. - G.T.
04-01-2013	Hydrocodone/APAP	10/325 mg	25	Respondent's P.A. - G.T.
04-10-2013	Hydrocodone/APAP	10/325 mg	45	Respondent's P.A. - G.T.
04-11-2013	Hydrocodone/APAP	10/325 mg	25	Respondent's P.A. - G.T.
04-17-2013	Carisoprodol	350 mg	60	Respondent's P.A. - G.T.
04-26-2013	Hydrocodone/APAP	10/325 mg	70	Respondent's P.A. - G.T.
05-11-2013	Hydrocodone/APAP	5/325 mg	12	Another Physician
05-13-2013	Hydrocodone/APAP	10/325 mg	70	Respondent's P.A. - G.T.
05-14-2013	Carisoprodol	350 mg	60	Respondent's P.A. - G.T.
05-31-2013	Hydrocodone/APAP	10/325 mg	45	Respondent's P.A. - G.T.
06-01-2013	Hydrocodone/APAP	10/325 mg	25	Respondent's P.A. - G.T.
06-17-2013	Hydrocodone/APAP	10/325 mg	45	Respondent's P.A. - G.T.
06-17-2013	Diazepam	10 mg	20	Respondent's P.A. - G.T.
06-17-2013	Carisoprodol	350 mg	40	Respondent's P.A. - G.T.
06-18-2013	Hydrocodone/APAP	10/325 mg	25	Respondent's P.A. - G.T.
07-01-2013	Hydrocodone/APAP	10/325 mg	45	Respondent's P.A. - G.T.
07-02-2013	Hydrocodone/APAP	10/325 mg	25	Respondent's P.A. - G.T.
07-03-2013	Hydrocodone/APAP	5/500 mg	10	Another Physician
07-04-2013	Carisoprodol	350 mg	40	Respondent's P.A. - G.T.
07-04-2013	Diazepam	10 mg	20	Respondent's P.A. - G.T.
08-14-2013	Diazepam	10 mg	60	Respondent
08-14-2013	Hydrocodone/APAP	10/325 mg	45	Respondent
08-14-2013	Carisoprodol	350 mg	60	Respondent
08-16-2013	Hydrocodone/APAP	10/325 mg	25	Respondent
08-27-2013	Hydrocodone/APAP	10/325 mg	25	Respondent
09-02-2013	Hydrocodone/APAP	10/325 mg	45	Respondent
09-10-2013	Carisoprodol	350 mg	60	Respondent

Date Filled	Drug Name	Strength	Quantity	Prescriber
09-13-2013	Diazepam	10 mg	60	Respondent
09-16-2013	Morphine Sulfate	15 mg	45	Respondent
09-16-2013	Hydrocodone/APAP	10/325 mg	25	Respondent
09-16-2013	Hydrocodone/APAP	10/325 mg	45	Respondent
10-06-2013	Hydrocodone/APAP	10/325 mg	45	Respondent
10-06-2013	Diazepam	10 mg	60	Respondent
10-06-2013	Carisoprodol	350 mg	60	Respondent
10-17-2013	Valium	10 mg	21	Another Physician
10-20-2013	Diazepam	10 mg	60	Respondent
10-20-2013	Hydrocodone/APAP	10/325 mg	25	Respondent
10-28-2013	Morphine Sulfate	15 mg	45	Respondent's P.A. - G.T.
11-01-2013	Hydrocodone/APAP	10/325 mg	70	Respondent's P.A. - G.T.
11-04-2013	Diazepam	10 mg	60	Respondent's P.A. - G.T.
11-08-2013	Carisoprodol	350 mg	20	Respondent
11-17-2013	Carisoprodol	350 mg	60	Respondent's P.A. - G.T.
11-26-2013	Diazepam	10 mg	20	Respondent
11-28-2013	Hydrocodone/APAP	10/325 mg	45	Respondent's P.A. - G.T.
11-29-2013	Morphine Sulfate	15 mg	45	Respondent's P.A. - G.T.
12-04-2013	Hydrocodone/APAP	10/325 mg	25	Respondent's P.A. - G.T.
12-07-2013	Diazepam	10 mg	60	Respondent's P.A. - G.T.
12-14-2013	Carisoprodol	350 mg	60	Respondent's P.A. - G.T.
03-06-2013	Carisoprodol	350 mg	60	Respondent's F.N.P. - L.M.[4]
03-06-2014	Diazepam	10 mg	60	Respondent's F.N.P. - L.M.
03-07-2014	Hydrocodone/APAP	10/325 mg	75	Respondent's F.N.P. - L.M.
04-24-2014	Hydrocodone/APAP	10/325 mg	75	Respondent's F.N.P. - L.M.
04-21-2014	Carisoprodol	350 mg	60	Respondent's F.N.P. - L.M.
04-21-2014	Diazepam	10 mg	60	Respondent's F.N.P. - L.M.
05-22-2014	Diazepam	10 mg	60	Respondent's F.N.P. - L.M.
05-22-2014	Hydrocodone/APAP	10/325 mg	45	Respondent's F.N.P. - L.M.
05-22-2014	Carisoprodol	350 mg	60	Respondent's F.N.P. - L.M.
06-05-2014	Hydrocodone/APAP	10/325 mg	45	Respondent's F.N.P. - L.M.
06-19-2014	Hydrocodone/APAP	10/325 mg	45	Respondent's F.N.P. - L.M.
07-03-2014	Hydrocodone/APAP	10/325 mg	15	Respondent's F.N.P. - L.M.

21. On or about July 21, 2014, one of respondent's practitioner's, B.J.,[5] had an office visit with patient M.C. The chief complaint is listed as "Refill Rx." The subjective section of the progress note indicates history of low back pain and patient diagnosed with slipped disc per

[4] According to the CURES report for patient M.C., some of her prescriptions were issued by Family Nurse Practitioner (F.N.P.) L.M. Respondent confirmed during his subject interview with a Health Quality Investigation Unit (HQIU) investigator that F.N.P. – L.M. used to work for him.

[5] According to the CURES report for patient M.C., the prescription for hydrocodone was filled by B.J. Respondent confirmed during his subject interview with a HQIU investigator that B.J. worked for him.

patient report. The examination section of the progress note has checkmarks next to general, respiratory, cardiovascular. There is no musculoskeletal or back exam noted. The assessment section of the progress note states "DM," HTN (hypertension), dysmenorrhea (menstrual cramps), sickle cell trait and LBP (low back pain). The plan section of the progress states L/S (lumbar spine) X-ray series 7-22-14, refill of metformin, clonidine and [illegible], labs, "spot urine," Soma 350 mg (#60), Norco 10/500 b.i.d. (twice a day) (#60), Claritin, Benadryl. The CURES report for this date indicates that patient M.C. filled prescriptions for Diazepam 10 mg (#30) and Soma 350 mg (#60). The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

22. According to the CURES report for patient M.C., during the period of on or about July 22, 2014, through November 11, 2014, patient M.C. filled the following prescriptions for the controlled substances listed below:

Date Filled	Drug Name	Strength	Quantity	Prescriber
07-22-2014	Hydrocodone/APAP	10/325 mg	45	Respondent
08-11-2014	Hydrocodone/APAP	10/325 mg	45	Respondent
08-27-2014	Carisoprodol	350 mg	60	Respondent's F.N.P. - L.M.
08-27-2014	Diazepam	10 mg	60	Respondent's F.N.P. - L.M.
09-01-2014	Hydrocodone/APAP	10/325 mg	30	Respondent
10-27-2014	Diazepam	10 mg	30	Respondent
10-27-2014	Carisoprodol	350 mg	60	Respondent
11-01-2014	APAP Codeine	30/300 mg	30	Another Physician

23. On or about November 12, 2014, respondent had an office visit with patient M.C. The chief complaint section for the note for this visit indicates the patient was seen for medication refill for sickle cell, blood pressure and glucose testing. The patient's depression was noted to be worse. There was no patient history listed. The physical examination indicated that the patient

"appears comfortable" with no indication of any back examination performed. The assessment was sickle cell by history "but negative lab result." The treatment plan included refilling medications and ordering labs. The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

24. According to the CURES report for patient M.C., during the period of on or about November 13, 2014, through June 15, 2015, patient M.C. filled the following prescriptions for the controlled substances listed below:

Date Filled	Drug Name	Strength	Quantity	Prescriber
11-13-2014	Diazepam	5 mg	30	Respondent
11-17-2014	Hydrocodone/APAP	10/325 mg	45	Respondent
11-25-2014	Carisoprodol	350 mg	60	Respondent
12-07-2014	APAP Codeine	30/300 mg	30	Another Physician
01-08-2015	Hydrocodone/APAP	5/325 mg	15	Another Physician
02-04-2015	Hydrocodone/APAP	10/325 mg	60	Respondent's P.A. - G.T.
03-02-2015	Diazepam	5 mg	30	Respondent
04-11-2015	Hydrocodone/APAP	5/325 mg	6	Another Physician

25. On or about June 16, 2015, one of respondent's practitioners, B.J., had an office visit with patient M.C. for STD screening, after her husband tested positive, and for a refill of her medications. According to the Progress Note for this visit, the patient's general examination, cardiovascular system, respiratory, and vaginal examination were normal. Among other things, the treatment plan included obtaining labs and a vaginal culture. The CURES report for this date, indicates that patient M.C. filled prescriptions for Diazepam 5 mg (#30) and hydrocodone/APAP 10/325 mg (#45). The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug

use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

26. On or about July 8, 2015, respondent's Physician Assistant G.T. had an office visit with patient M.C. to be seen for continued back pain. The note for this visit indicates that the patient's general examination, head, eyes, ears, nose and throat (HEENT), neck, cardio and respiratory examination were normal. There was no documented examination of the patient's back. The assessment was disc prolapse, anxiety, diabetes, and HTN. The treatment plan included ordering labs, refilling medications, and to obtain an MRI of the spine to rule out disc prolapse. The progress note for the visit did not identify the name of the supervising physician for Physician Assistant G.T. and there is no co-signature by respondent as the supervising physician of Physician Assistant G.T. On this date, Physician Assistant G.T. prescribed hydrocodone/APAP 10/325 mg (#90)[6] and Diazepam 10 mg (#60). There is no indication that the MRI of the spine was actually performed. There also was no justification documented for increasing the Diazepam from 5 mg (#30) to 10 mg (#60). The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

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[6] The Drug Enforcement Administration reclassified hydrocodone combination products from Schedule III to Schedule II effective October 6, 2014. Section 3502.1, subd. (e)(1) provides, in pertinent part, "The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed, countersigned, and dated by a supervising physician and surgeon within seven days."

27. On or about August 5, 2015, respondent's Physician Assistant G.T. had an office visit with patient M.C. who was requesting refill of medications and Metformin for her diabetes. The examination was listed as normal for general, HEENT, neck, cardio and respiratory, cardiovascular; and abnormal for the patient's back with a notation of "severe pain lower back, paraspinous tendernesss." The assessment section of the note for this visit listed diagnoses of chronic bronchitis, weight gain, anxiety, diabetes and HTN. The treatment plan included "patient needs MRI ASAP [and] refill meds Valium/Norco." The progress note also indicates "after MRI results will authorize pain management or orthopedics." There is no indication that patient M.C. ever had a pain management or orthopedics consultation. Physician Assistant G.T. wrote the patient a prescription for hydrocodone APAP 10/325 mg (# 90). The progress note for the visit did not identify the name of the supervising physician for Physician Assistant G.T. and there is no co-signature by respondent as the supervising physician of Physician Assistant G.T. The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

28. According to the CURES report for patient M.C., during the period of August 6, 2015, through October 29, 2015,[7] patient M.C. filled the following prescriptions for controlled substances:

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[7] During this period of time, there was one clinic visit by patient M.C. on September 30, 2015, in which she got "verbal" with one of the office staff and called her a "bitch" because the staff member could not accommodate a "walk-in" visit. The progress note for this visit indicates no vital signs being recorded, no physical examination, and no assessment and plan presumably because patient M.C. could not be accommodated on this date.

Date Filled	Drug Name	Strength	Quantity	Prescriber
09-02-2015	Hydrocodone/APAP	10/325 mg	90	Respondent's P.A. - G.T.
09-30-2015	Hydrocodone/APAP	10/325 mg	90	Respondent's P.A. - G.T.
10-29-2015	Carisoprodol	350 mg	60	Respondent's P.A. - G.T.

29. Respondent committed gross negligence[8] in his care and treatment of M.C., which included, but was not limited to, the following:

(a) Respondent and/or his physician assistant failed to maintain adequate and accurate medical records in his care and treatment of patient M.C., and prior to prescribing and/or refilling narcotic and controlled substances to patient M.C., because the medical record documentation consistently lacked adequate detail and specificity, was often illegible and/or difficult to decipher in whole or part, and failed to adequately document initial and ongoing mental health and alcohol/drug use history, failed to document any informed consent, consistently failed to record the narcotics and controlled substances that were being prescribed or refilled, consistently failed to document an adequate treatment plan and/or functional goals with stated objectives for the patient's care, consistently there was no medical record documentation for many of the narcotics and controlled substances that were prescribed or refilled for patient M.C.; and some of the notes did not identify the name of the supervising physician for Physician Assistant G.T. and were missing a co-signature by respondent as the supervising physician of Physician Assistant G.T. and

(b) Respondent and/or his physician assistant repeatedly prescribed or refilled narcotics and controlled substances to patient M.C. without conducting adequate ongoing monitoring and periodic assessment for the narcotics and controlled substances that were being prescribed or refilled including, but not

[8] Respondent is responsible for any acts of his physician assistant because "a physician assistant acts as an agent of the supervising physician..." and, as such, "the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician." (Bus. & Prof. Code, § 3501, subd. (b); and Cal. Code Regs., tit. 16, § 1399.541.)

limited to, timely follow up visits and appropriate assessment of response to therapy.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

30. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients M.C. and T.A., which included, but was not limited to, the following:

PATIENT T.A.

31. On or about November 10, 2008, patient T.A., a then-24 year old male, had his initial office visit at respondent's clinic with Physician Assistant G.T.[9] The patient presented with complaints of cough, stuffy nose, congestion and sore throat. The intake documentation indicates a problem list of autism, A.D.D. (Attention Deficit Disorder), scoliosis and severe back pain and a medication list that included carisoprodol (Soma), Vicodin and some other medication that is illegible. According to the Progress Note for this visit, the patient was documented as having normal HEENT, neck, heart and abdomen. The treatment plan included medications: Tylenol 325 mg (#30) every four hours; Phenergan, 2 tablespoons every 4 hours and Amoxicillin. On this date, patient T.A., executed a Pain Management and Policy on Controlled Substances ("Pain Management Policy") which provided, in pertinent part:

> ". . . [¶] X-rays may demonstrate degenerative joint and disc disease and MUST be obtained. If you do not have the results of these tests or x-rays with you or if we cannot obtain the information while you are here, then we will arrange for you to get the appropriate tests or X-rays.
>
> "Dr. Pierson may use muscle relaxers, stretching exercises, electro-stimulation therapy and local injection into the back or joints. The doctor may try these methods BEFORE using controlled substances...
>
> "If it is determined [¶] (AFTER your X-rays and blood tests have been completed and [¶] AFTER the results are back in your chart) [¶] then, if indicated, these prescriptions may be prescribed. (Emphasis in original.) . . . "

[9] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

As established herein, respondent did not comply with the Pain Management Policy because he did not consider other non-controlled substances treatments and he and/or his physician assistant(s) and/or family nurse practitioner's prescribed and/or refilled prescriptions for controlled substances without there being any X-ray results "back in [patient T.A.'s]' chart." The Progress Note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

32. On or about October 21, 2009, respondent had an office visit with patient T.A. According to the progress note for this visit, the patient was seen for severe pain in his back for the past month, ringworm on the side of his neck and coughing for two months. A limited physical examination was conducted which was normal for the neck, chest, heart abdomen; and abnormal for the extremities and skin. The assessment included post nasal drip, a wart on a finger, and autism ruling out Asperger's syndrome and schizophrenia.[10] The plan included, but was not limited to, medications for the ringworm and post-nasal drip, referral to another physician for wart removal and a psychiatric referral. There is no indication that the psychiatric referral was ever completed. The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan

[10] A work form completed by respondent indicated that patient T.A.'s symptoms apparently started at birth and that the patient has difficulty adapting to stress and does not posses many skills for work. The patient was noted to be on psychotropic medications as a result of his cognitive limitations and his ability to follow directions.

for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

33. On or about January 20, 2010, respondent had a follow up office visit with patient T.A. According to the progress note for this visit, the patient had "back pain since last visit!" A limited physical examination was conducted which was normal for the neck, lymph nodes, chest, lungs, abdomen and extremities; and abnormal for the back examination with a notation of decreased range of motion and tenderness at the lumbosacral spine. The assessment was low back pain and resolution of the ringworm on the neck that was present at the last office visit. The treatment plan of the lower back pain included ordering an X-ray series of the lumbosacral spine area and to return to clinic in approximately one month. There is no indication that the X-rays were actually completed. The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

34. On or about January 12, 2011, respondent had an office visit with patient T.A. According to the History and Physical Form for this visit, the patient presented with back pain and coughing for two days. The review of systems was within normal limits except for the patient's back which was noted as "low back pain – stiffness." The patient's physical examination was normal in the areas of neck, chest, heart, rectal extremities, skin and neurological. The physical exam documented issues with the patient's mental status noted as "disoriented – poor historian," his abdomen with a notation of "mild obesity," and his back which was noted to have a decreased range of motion with mild to moderate paraspinous muscle spasm and pain with flexion. The assessment was pharyngitis, cough and chronic low back pain

"acutely exacerbated." The treatment plan was Keflex, Phenergan DM, Indomethacin, Tylenol with codeine and a drug screen that was never done. The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

35. On or about January 11, 2012, Physician Assistant G.T. had an office visit with patient T.A. According to the History and Physical Form for this visit, the patient presented with back pain and sore throat. For the history or present illness section, the patient was noted as being "non verbal." The note contains checkmarks for the boxes for mental status (listed as abnormal with an associated comment of "nonverbal"; normal for HEENT, neck, chest, heart, lungs, lymphatic system; and abnormal for back with a notation of "indicates back pain."[11] The note associated with this visit is cursory, the progress note for the visit did not identify the name of the supervising physician for Physician Assistant G.T. and there is no co-signature by respondent as the supervising physician of Physician Assistant G.T. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

[11] The medical record for this particular visit does not have a clearly marked page 2 for the visit of January 11, 2012. There is a undated page 2 within the certified medical records that were produced by respondent but it is unclear as to whether the undated page 2 is associated with the visit of January 11, 2012.

36. According to the CURES report for patient T.A., during the period of January 12, 2012, through July 18, 2012,[12] patient T.A. filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity	Prescriber
01-16-2012	Carisoprodol	350 mg	30	Respondent's P.A. - G.T.
01-16-2012	Hydrocodone/APAP	5/500 mg	30	Respondent's P.A. - G.T.
01-28-2012	Hydrocodone/APAP	5/500 mg	30	Respondent's P.A. - G.T.
02-03-2012	Hydrocodone/APAP	5/500 mg	30	Respondent's P.A. - G.T.
02-11-2012	Hydrocodone/APAP	5/500 mg	30	Respondent's P.A. - G.T.
02-11-2012	Carisoprodol	350 mg	30	Respondent's P.A. - G.T.
02-23-2012	Hydrocodone/APAP	5/500 mg	15	Respondent's P.A. - G.T.
02-24-2012	Carisoprodol	350 mg	30	Respondent's P.A. - G.T.
03-04-2012	Hydrocodone/APAP	5/500 mg	56	Respondent's P.A. - G.T.
06-14-2012	Carisoprodol	350 mg	30	Respondent's P.A. - G.T.
06-14-2012	Hydrocodone/APAP	5/500 mg	30	Respondent's P.A. - G.T.
06-23-2012	Hydrocodone/APAP	5/500 mg	26	Respondent's P.A. - G.T.
07-06-2012	Carisoprodol	350 mg	30	Respondent's P.A. - G.T.
07-16-2012	Hydrocodone/APAP	5/500 mg	26	Respondent's P.A. - G.T.

37. On or about July 19, 2012, respondent had an office visit with patient T.A. According to the Progress Note for this visit, the patient's chief complaint was back pain and sore throat. As can best be discerned from the note for this visit, the assessment was pharyngitis, chronic low back pain and vitamin D deficiency. The treatment plan included obtaining a throat culture and medications. On this date, patient T.A. filled a prescription for carisoprodol (Soma) 350 mg (#30) that was prescribed by respondent. The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or

[12] Within this period of time, there is a progress note for April 10, 2012, that indicates "pt [patient] c/o [complains of] Lab Results." There is no other significant information set forth on the progress note for April 10, 2012, and nothing to indicate that patient T.A. was examined on this date.

misuse of the controlled substances being prescribed.

38. According to the CURES report for patient T.A., during the period of July 20, 2012, through March 17, 2013, patient T.A. filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity	Prescriber
07-22-2012	Hydrocodone/APAP	5/500 mg	30	Respondent
08-02-2012	Hydrocodone/APAP	5/500 mg	30	Respondent
08-02-2012	Carisoprodol	350 mg	30	Respondent
08-19-2012	Hydrocodone/APAP	5/500 mg	30	Respondent
09-03-2012	Hydrocodone/APAP	5/500 mg	5	Another Physician
09-24-2012	Carisoprodol	350 mg	30	Respondent's P.A. - G.T.
10-22-2012	Carisoprodol	350 mg	30	Respondent's P.A. - G.T.
11-10-2012	Carisoprodol	350 mg	30	Respondent's P.A. - G.T.
11-21-2012	Carisoprodol	350 mg	30	Respondent's P.A. - G.T.
01-09-2012	Hydrocodone/APAP	5/500 mg	30	Respondent
01-09-2013	Carisoprodol	350 mg	60	Respondent
01-18-2013	Hydrocodone/APAP	5/500 mg	30	Respondent
01-28-2013	Hydrocodone/APAP	5/500 mg	30	Respondent
01-28-2013	Carisoprodol	350 mg	60	Respondent
02-20-2013	Carisoprodol	350 mg	60	Respondent
02-20-2013	Hydrocodone/APAP	5/500 mg	30	Respondent
03-07-2013	Hydrocodone/APAP	5/500 mg	30	Respondent
03-07-2013	Carisoprodol	350 mg	60	Respondent

39. On or about March 18, 2013, respondent's Physician Assistant G.T. had an office visit with patient T.A. According to the Progress Note for this visit, the chief complaint was coughing with a notation for "paperwork" and to "refill [medications]." The note contains checkmarks for the boxes for HEENT, respiratory, cardiovascular, abdomen, neurological and extremities but there is no indication as to whether those areas were normal or abnormal. The portion of the note for past medical history, surgical history and whether the patient used tobacco, alcohol and/or drugs is not filled out. The treatment plan included prescriptions for Vicodin ES (#60) every six hours; carisoprodol (Soma) 350 mg (#30) and Mobic (#30). On this date, patient T.A. filled a prescription for carisoprodol (Soma) 350 mg (#30) that was prescribed by Physician Assistant G.T. The note associated with this visit is cursory and there is no co-signature by respondent as the supervising physician of Physician Assistant G.T. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug

use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

40. According to the CURES report for patient T.A., during the period of March 19, 2013, through April 30, 2013, patient T.A. filled the following prescriptions for controlled substances set forth below. In the medical records produced by respondent, there is no rationale documented for the increase in the prescriptions for carisoprodol (Soma) from 350 mg (#30) to 350 mg (#60) and Hydrocodone APAP 5/500 mg (#30) on March 7, 2013, to 7.5/750 mg (#60).

Date Filled	Drug Name	Strength	Quantity	Prescriber
03-19-2013	Hydrocodone/APAP	7.5/750 mg	60	Respondent's P.A. – G.T.
04-01-2013	Carisoprodol	350 mg	30	Respondent's P.A. – G.T.
04-04-2013	Carisoprodol	350 mg	60	Respondent
04-04-2013	Hydrocodone/APAP	7.5/750 mg	60	Respondent

41. On or about May 1, 2013, respondent had an office visit with patient T.A. According to the Progress Note for this visit, the chief complaints were that the patient had back pain, pain in neck of 8 out of 10 and he was tired. The note contains checkmarks for the boxes for General, HEENT, respiratory, cardiovascular, abdomen, and neurological but there is no indication as to whether those areas were normal or abnormal. The portion of the note for past medical history, surgical history and whether the patient used tobacco, alcohol and/or drugs is not filled out. Respondent documented that the patient appeared fatigued and had a positive finding on the straight leg test. The assessment was chronic low back pain and radiculopathy. The treatment plan was to refill medications. On this date, patient T.A. filled prescriptions for hydrocodone APAP 7.5/750 mg (#60) and carisoprodol (Soma) 350 mg (#60) that were issued by respondent. The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being

prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

42. According to the CURES report for patient T.A., during the period of May 2, 2013, through June 9, 2014, patient T.A. filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity	Prescriber
05-26-2013	Hydrocodone/APAP	7.5/750 mg	60	Respondent
05-26-2013	Carisoprodol	350 mg	60	Respondent

43. On or about June 10, 2014, respondent had an office visit with patient T.A. According to the Physical Exam note for this visit, the chief complaint was back pain with a notation under the subjective section of the note indicating "no new complaints" and refill medications and "paperwork." The note contains checkmarks indicating HEENT, respiratory, cardiovascular, abdomen and neuro were normal. Respondent noted that the back had decreased range of motion and a "Late Entry," with no indication of when the late entry was made, stating "Local tenderness at paraspinous muscle group along L/S spine." The assessment was ADD and back pain. The treatment plan was to obtains labs, EKG and a drug screen with a notation that the blood work, EKG and an X-ray series of the L/S spine were refused. Respondent refilled medications but failed to list what specific medications were being filled. The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, pain level, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

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44. According to the CURES report for patient T.A., during the period of June 11, 2014, through September 29, 2015, patient T.A. filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity	Prescriber
06-12-2014	Carisoprodol	350 mg	60	Respondent
06-12-2014	Hydrocodone/APAP	10/325 mg	60	Respondent
07-07-2014	Carisoprodol	350 mg	60	Respondent
07-07-2014	Hydrocodone/APAP	10/325 mg	60	Respondent
08-03-2014	Carisoprodol	350 mg	60	Respondent
08-03-2014	Hydrocodone/APAP	10/325 mg	60	Respondent
08-31-2014	Carisoprodol	350 mg	60	Respondent
08-31-2014	Hydrocodone/APAP	10/325 mg	60	Respondent
09-29-2014	Carisoprodol	350 mg	60	Respondent
09-29-2014	Hydrocodone/APAP	10/325 mg	60	Respondent

45. On or about April 28, 2015, patient T.A. had an office visit at respondent's clinic. The medical note for this visit does not clearly indicate who saw the patient on this date. According to the Progress Note for this visit, the patient's chief complaint was back pain and ADD with the subjective complaints listed as back pain of 10 out of 10, muscle spasm, insomnia and coughing for four days. Notes of the limited examination appear to indicate the patient was alert and oriented x 3, and within normal limits for HEENT, respiratory, cardiovascular, and intact neurological. The assessment was back pain, scoliosis, and ADHD. The documented treatment plan was "problem discussed with patient" and to refill the patients medications: hydrocodone APAP (Norco) 7.5/325 mg, carisoprodol (Soma) 350 mg, zolpidem tartrate (Ambien) 5 mg (#30) and Mobic. The note associated with this visit is cursory. Among other things, the documentation is lacking and/or inadequate in regard to past medical history, functional goals with stated objectives, and/or specifics regarding past or current alcohol or drug use or abuse. In addition, the documentation is lacking and/or inadequate regarding informed consent for the controlled substances being prescribed and there is no detailed management plan for the patient and/or any documentation indicating drug screening, efforts to monitor compliance and/or measures to ensure there was no diversion of controlled substances or misuse of the controlled substances being prescribed.

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46. Respondent committed repeated negligent acts in his care and treatment of T.A., which included, but were not limited to, the following:

(a) Respondent and/or his physician assistant repeatedly prescribed or refilled narcotics and controlled substances to patient T.A. without obtaining an adequate and appropriate history and physical examination including, but not limited to, obtaining a detailed history in regard to patient T.A.'s physical and/or mental health, reviewing and/or verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition, regularly obtaining past or present pain scores, functional goals with stated objectives and/or obtaining imaging or other objective testing, failing to properly work up patient anxiety condition, and failing to consider other possible alternative treatments besides narcotics and controlled substances;

(b) Respondent and/or his physician assistant failed to maintain adequate and accurate medical records in his care and treatment of patient T.A., and prior to prescribing and/or refilling narcotic and controlled substances to patient T.A., because the medical record documentation consistently lacked adequate detail and specificity, was often illegible and/or difficult to decipher in whole or part, and the failed to adequately document initial and ongoing mental health and alcohol/drug use history, failed to document any informed consent, consistently failed to record the narcotics and controlled substances that were being prescribed or refilled, consistently failed to document an adequate treatment plan and/or functional goals with stated objectives for the patient's care, consistently there was no medical record documentation for many of the narcotics and controlled substances that were prescribed or refilled for patient T.A.; and some of the notes did not identify the name of the supervising physician for Physician Assistant G.T. and were missing a co-signature by respondent as the supervising physician of Physician Assistant G.T.; and

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(c) Respondent and/or his physician assistant repeatedly prescribed or refilled narcotics and controlled substances to patient T.A.; without conducting adequate ongoing monitoring and periodic assessment for the narcotics and controlled substances that were being prescribed or refilled including, but not limited to, timely follow up visits and appropriate assessment of response to therapy;

47. Respondent committed repeated negligent acts in his care and treatment of M.C., which included, but were not limited to, the following:

(a) Paragraphs 16 through 29, above, are hereby incorporated by reference and realleged as if fully set forth herein.

(b) Respondent and/or his physician assistant repeatedly prescribed or refilled narcotics and controlled substances to patient M.C. without obtaining an adequate and appropriate history and physical examination including, but not limited to, obtaining a detailed history in regard to patient M.C.'s physical and/or mental health, reviewing and/or verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition, regularly obtaining past or present pain scores, functional goals with stated objectives and/or obtaining imaging or other objective testing, failing to properly work up patient M.C.'s anxiety condition, and failing to consider other possible alternative treatments besides narcotics and controlled substances;

(c) Respondent and/or his physician assistant failed to maintain adequate and accurate medical records in his care and treatment of patient M.C., and prior to prescribing and/or refilling narcotic and controlled substances to patient M.C., because the medical record documentation consistently lacked adequate detail and specificity, was often illegible and/or difficult to decipher in whole or part, and he failed to adequately document initial and ongoing mental health and alcohol/drug use history, failed to document any informed consent, consistently failed to record the narcotics and controlled substances that were being prescribed or refilled,

consistently failed to document an adequate treatment plan and/or functional goals with stated objectives for the patient's care, consistently there was no medical record documentation for many of the narcotics and controlled substances that were prescribed or refilled for patient M.C.; and some of the notes did not identify the name of the supervising physician for Physician Assistant G.T. and were missing a co-signature by respondent as the supervising physician of Physician Assistant G.T.

(d) Respondent and/or his physician assistant repeatedly prescribed or refilled narcotics and controlled substances to patient M.C. without conducting adequate ongoing monitoring and periodic assessment for the narcotics and controlled substances that were being prescribed or refilled including, but not limited to, timely follow up visits and appropriate assessment of response to therapy.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

48. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he and/or his physician assistant failed to maintain adequate and accurate records in his care and treatment of patients M.C. and T.A., as more particularly alleged in paragraphs 16 through 47, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Number G53815, issued to respondent Joseph E. Pierson, M.D.;

2. Revoking, suspending or denying approval of respondent Joseph E. Pierson, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code and advanced practiced nurses;

3. Ordering respondent Joseph E. Pierson, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: October 16, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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